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ABSTRACT

There is no national policy on assisting drug-using pregnant mothers nor on the children they produce. This paper looks at the issue of "crack-cocaine" and mothers who give birth to children after using drugs during pregnancy. It attempts to lay out what is known, and it puts forth "best guesses" regarding helping children born affected by drugs. Several aspects of the crack-cocaine epidemic and the "crack kids" problem are outlined under the headings: (1) How Great Is the Risk? (2) What Are the Costs? (3) Some Successful Programs; (4) Legal and Ethical Issues; and (5) A New Version of the Social Contract: The "Prevention Contract." Among the conclusions are the following: while some children cannot be helped, many can be brought to normal or near normal functioning by highly intensive (and expensive) programs; increased use of crack by females has produced increased rates of veneral disease and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) among women who turn to prostitution to support their habit; only a handful of drug treatment centers around the country will accept pregnant women; there is some conflict between the goals of prevention and the goals of treatment; and there are virtually no reliable state data on children born with dangerous drugs in their bloodstream. (Contains 26 references.) (LL)

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AGAINST THEIR WILLS:
Children Born Affected by Drugs

by
Harold L. Hodgkinson
and
Janice Hamilton Outtz

SP034839

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July 1993

PREFACE

When we began this investigation in 1991, we quickly realized that the press and television had seen "crack kids" as an epidemic around 1984-85. While the later 1980s produced a variety of studies, studies showing the exact nature of the extent of drug use by pregnant mothers and the consequences for their children are very disappointing and almost nonexistent. Most of the sources use the same small number of national studies which deal primarily with the medical aspects of drug use by pregnant mothers. What we found particularly lacking in the existing research was the demographic component. We were unable to find answers to such fundamental questions as how many drug-affected children are there exactly? What kind of families do they come from? Do they live just in the cities, or is it as much a problem in the suburbs and rural areas? Are there differences in terms of educational attainment, income, etc.?

What is now clear, however, is that there are some promising treatments available. These treatments are usually costly. And, if they were to be made available to all children who could benefit, the cost would be astronomical. In 1993, there is no national policy on assisting drug-using pregnant mothers, nor on the children they produce. Most states are in the same situation. And for some reason, the issue began to virtually disappear from public view, beginning about Spring 1992. Reasons for this are not clear.

We have learned a few things about the crack-cocaine epidemic, however. The number of women seeking treatment for crack, VD and AIDS, children born with drug-related problems, children who were left in the hospital as "boarder babies" and cases of child abuse and neglect ending in foster care, as well as preschool special education requests, have all expanded exponentially. We also know about programs that are working.

What we have attempted to do in this report is to lay out what is known and not known, and put forth "best guesses" regarding helping children born affected by drugs. Special thanks must go to the Metropolitan Life Foundation for their support, and most especially for their patience as we struggled to get a handle on this difficult topic. We would also like to thank Anita M. Obarakpor, Research Associate at IEL's Center for Demographic Policy, for assistance with data collection and editing the report. Michael Usdan, President of IEL, and Louise Clarke, Chief Administrator Officer, provided their usual welcomed support and editorial assistance. Errors of fact in interpretation, however, remain the responsibility of the authors. The opinions expressed in this report do not necessarily reflect the views or positions of the Metropolitan Life Foundation.

Harold L. Hodgkinson
Janice Hamilton Outtz
July 1993

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Against Their Wills:

Introduction

America's involvement with addictive drugs has a long history. While alcohol has been the "drug of choice" (archeological digs make it clear that fermentation has been a part of virtually all human communities), the 1880s produced a new drug. This drug, which was available at every drug store in the United States, was guaranteed to cure everything from a toothache to a headache to depression. Pregnant women used it regularly to "keep up their spirits." A major soft drink, sold as a "pepper-upper" used both the name and the ingredient in its original formula. The drug was cocaine, universally available without prescription over a century ago in the United States. Although tobacco was limited to male consumption since Sir Walter Raleigh's time, the Women's Suffrage movement fought for the right to vote AND to smoke. Morphine eased the pain of soldiers in the First World War, and created many addicts. Heroin was developed as a substitute, but became equally addictive. Many middle-class women were addicted to patent medicines that contained powerful drugs; and according to sociologist Stephanie Coontz, pharmacists routinely dispatched young messenger boys to people's homes with vials of morphine.

A sophisticated underground system distributed heroin and opium, but few people were killed in the process. Even with cocaine, which required advanced knowledge of chemistry and dangerously high heat plus a lot of time which made apprehension easier, profits and death from usage were low. What was needed by the drug "industry" was a drug that produced a virtually instantaneous high without needles and other paraphernalia, that could be quickly manufactured, easily hidden, and that could also be sold without the buyer coming to a central place. That substance, which was created, not discovered, was "crack cocaine" -- a mixture of cocaine plus baking soda.

American life has not been the same since this creation which "hit the streets" in the 1980s. The profitability of crack has no equal. The quick, intense high is

followed by a very pronounced low, virtually requiring another hit to make the low go away. No substance can cause addiction as rapidly. Thousands of dollars could be made in less that an hour, which explains the connection between crack and guns and violence, as very young gangs fight to the death for control of prime distribution territory.

Heroin was distributed by middle-aged males; crack by children and teens who tend to do what they're told and know little to incriminate those higher up in the system. Unlike the drug epidemics of the 1960s and 1970s, which primarily involved men addicted to heroin, the current drug epidemic has affected many women of childbearing age. Women who were not keen on injecting themselves with heroin found the crack pipe a simple and easily hidden tool. Women crack addicts often turned to prostitution to support their crack habit, increasing the AIDS and venereal disease rates very rapidly. They also had the capacity to transmit any or all of the substances we have discussed, through the placenta and via the umbilical cord of any child they happened to be carrying. While women have always had this ability, the explosion of crack (sometime around 1984) seemed to have caused an epidemic of children who showed unusual behavior almost from the moment of birth. The noted pediatrician, T. Berry Brazelton, agrees that "intrauterine exposure to drugs is the epidemic of the 1990s."

The number of women seeking treatment for crack, VD and AIDS, children born with drug-related problems, children who were left in the hospital as "boarder babies" and cases of child abuse and neglect ending up with foster care, as well as pre-school special education requests, all expanded exponentially. By 1985, the national media began discussing a "bio underclass" of "crack kids" who seemed incapable of becoming human. In 1993, we have learned a few things about the crack-cocaine epidemic, but not many. This report will attempt to lay out what is known, what is not, and the "best guesses" regarding children born affected by drugs against their wills.

How Great Is The Risk?

There is no universal behavior profile of children who have been exposed to crack-cocaine in utero. Most drug-using women are polydrug users, making it virtually impossible to isolate the effects of any one drug on their offspring. The first reports on drug-exposed children were spectacular and nearly all negative: ALL children whose mothers used drugs during pregnancy, especially crack cocaine, were

addicted themselves and were called such names as "bio underclass," "children of the damned," or just "crack kids."

Most of the studies dealing with "crack babies" are more often studies of children whose mothers used more than one drug, including alcohol and cigarettes. Alcohol, crack and tobacco use by the mother during pregnancy can all produce a list of abnormalities which includes: stiffness, irritability, frequent startling, tremors, irregular sleeping, poor feeding, poor social interaction, aversion of eye contact, lack of "playing" with objects and people, lethargy and hyperactivity. The medical experts also say that some children who have been exposed to drugs before birth later on exhibit tremors, language delays, poor task organizational ability, and attachment and separation problems.

Most of the studies dealing with "crack babies" are studies of children whose mothers used more than one drug, including alcohol and cigarettes.

The National Association for Perinatal Addiction Research and Education (NAPARE) is conducting a longitudinal study of the developmental progress of 300 children who were prenatally exposed to illicit drugs. The study, the lengthiest in the nation, provides some encouraging data for anyone involved with educating or caring for the children. According to the findings reported by the *Kappan Special Report* (*Phi Delta Kappan*, 1992):

- Almost 100% of the drug-exposed children test within normal range cognitively. (This means that they can be taught, and they can learn.)
- While all drug-exposed children exhibit signs of neurobehavioral deficiencies as infants, the majority of them at ages 3 and 4 have achieved levels of social, emotional, and intellectual development that place them within the normal range.
- Between 30% and 40% of the cocaine-exposed children continue to display problems of varying degrees of severity in language development and/or attention. Attention difficulties range from mild distractibility to attention deficit disorder with hyperactivity. However, less than 5% of these children exhibit true attention deficit disorder with hyperactivity.

Cocaine, researchers know, is very harmful to the fetus. When pregnant women use crack, the cocaine constricts the blood vessels in the placenta and the fetus, cutting off the flow of oxygen and nutrients and often causing miscarriages, stillbirths, and premature, low birth weight births. A research study by Dr. I.J. Chasnoff of Northwestern University School of Medicine in Chicago, found that there was an increase in complications of labor and delivery in cocaine-addicted women and an increase in the rate of sudden infant death in the cocaine-exposed infants.

The majority of women of childbearing age who abuse drugs suffer from many social, psychological, and economic problems. In addition, drug-affected women are at risk of venereal diseases, AIDS, poor nutrition and physical health. Many do not get adequate (if any) prenatal health care. In fact, research studies show that cocaine-addicted women had a high incidence of infectious disease complications, especially hepatitis and venereal disease. All of these factors *can* also have a damaging effect on an unborn child.

Not all researchers are convinced that the rash of crack-exposed children presents a kind of medical problem that is very different from that presented by children exposed to other drugs or inadequate prenatal health care and general neglect and abuse. But no one is sure, since there is no test of a newborn for crack-cocaine exposure, only cocaine.

This test for cocaine, which is only valid for the previous 24 to 48 hours, misses a large number of cases. A mother who used crack until two days before she went to the hospital for delivery would not test positively for cocaine; nor would the child she delivered. In addition, cocaine can also be transmitted to the baby through breast milk, if the mother breast feeds her baby.

Because the mother who tested positive for drug use wishes to avoid prosecution, or because she feels that she can't care for the baby, she often leaves her newborn in the hospital to become a "boarder baby." Finding an adoptive home for the children left at the hospital is difficult. And foster care facilities are easily overwhelmed by the number of children being placed today. The doubling (or tripling in some instances) of foster care placement requests since 1986 along with the doubling of pre-school special education requests are consistent with a major increase in drug use by pregnant mothers, particularly cocaine, according to some researchers such as Mathea Falco (1991).

According to the experts, we have an increasing number of babies to deal with, although they disagree as to how many. The *Kappan Special Report* (1992) called the problem "a social epidemic." Current data show that between 100,000 and nearly 500,000 children are born each year in the United States to mothers who used

By 2000, as many as four million drug-exposed children will be attending school.

harmful drugs during pregnancy. Data also show that crack-cocaine is the most rapidly increasing drug ingested by these mothers, even though most are poly-drug users. U.S. Representative Charles Rangel (D-NY), who chairs the House Select Committee on Narcotics Abuse and Control, reported at a recent hearing that some hospitals nationwide had reported that over 20 percent of their deliveries are infants who were prenatally exposed to drugs. The truth of the matter is that even today, no one really knows how many babies are born affected. The NAPARE estimated that in 1989 there were 375,000 babies born exposed to ***all types*** of illegal drugs per year. Other experts have shown varying numbers. The National Institute on Drug Abuse estimates that the number of drug-exposed children born each year ranges from 375,000 to 739,000, possibly 18 percent of all newborns in the United States. Dr. T. Berry Brazelton said at one of the hearings of Rangel's subcommittee that "the threat (of drug abuse and intrauterine exposure to drugs) is like a tidal wave."

We know that these children are already in our schools and educators are having to deal with them. Both the medical and educational experts have come together to design programs needed to help these children. Furthermore, their numbers are increasing. The March of Dimes predicts that by the year 2000, as many as four million drug-exposed children will be attending school (*Kappan Special Report*, 1992).

It is reasonable to assume that many drug-using women (especially crack users) will resort to prostitution as a way of supporting their drug habit, thus increasing AIDS and venereal disease rates among women. It is also reasonable to assume that pregnant women who go to public hospitals are more likely to be identified as drug users than women who go to private (suburban) ones, where wealth and social standing put pressure on the hospital to keep this information confidential.

Crack is used in all segments of society, but unevenly reported and prosecuted. According to the 1992 *Kappan Special Report*, a recent study in Pinellas County, Florida, conducted by the NAPARE, found that low-income minority women were 10 times more likely to be reported as drug users. But urine tests of 3,000 pregnant women in both private and public health facilities showed that middle-class women used illicit drugs at virtually the same rate. A study published in the *New England Journal of Medicine* found that rates of substance abuse are slightly higher for white women than for nonwhite women, even though the latter are ten times as likely as white women to be reported for such abuse. In addition, access to services which will minimize the effect of the drug on both mother and child is usually available to those who can pay, and is not available to those who can't. The only

differential that works is propinquity - doctors and nurses have high rates of addiction, as do poor people, for the same reason - drugs are everywhere in their environment.

It is also likely and documented that most **private** hospitals do not test pregnant women who are admitted for delivery for drug use. Thus, the very high number of poor, inner city, and minority women identified as drug-using mothers is as much a bias of reporting as a behavioral fact.

While the experts disagree on the both the number and the exact results of treatment, it would seem that of the total number of drug-affected kids (375,000 a year seems conservative, according to the estimates), maybe one-third of the babies who receive intense and expensive care, support, and specially trained teachers and social workers, can become entirely "normal." Another third can remove many deficits through such programs, but will still be unable to attain normal functioning in all areas. The last third will have serious functioning problems that are the result of damage to the central nervous system that cannot be eliminated by special programs.

While these predictions may appear to be based on the extent of neonatal damage, it is also important to point out that the "most favored" third will also come disproportionately from the most supportive and dedicated home environments. In addition, the successful programs in working with drug-exposed children are very expensive in terms of training, diagnostics, and number of children supervised by an adult. It is not yet clear that voters are willing to allow these expenditures for the entire population of about 375,000 drug-exposed children a year, particularly when such increases will probably mean reductions in other youth policy areas, such as gifted and talented children, Head Start, WIC, etc. Obviously, ALL of the 375,000 children will be better off in more supportive environments, but the question of what society is willing to pay for looms large in this decision.

Drug treatment and prenatal care could reduce the number of drug-exposed babies but there is much resistance to expanding drug treatment facilities. In addition to the cost, there is often community opposition to placing a local treatment center "in my back yard" even though existing centers do not decrease property values, nor do they increase crime. Additionally, money for staffing such centers has fallen way behind demand. Basically, all across the nation in 1993, there are long waiting lists for access to drug treatment programs, particularly those that serve both mother and child.

A 1990 survey conducted by the National Association of State Alcohol and Drug Abuse Directors, Inc., estimates that 280,000 pregnant women nationwide were in need of drug treatment, yet less than 11 percent of them received care. Hospital and social welfare officials also report that drug treatment services were insufficient

or inadequate to meet the demand for services of drug-addicted pregnant women. In addition to insufficient or inadequate treatment, some treatment programs deny services to drug-addicted pregnant women and others lack child care services for the pregnant addicts' other children. Clearly, even in the handful of clinics that accept pregnant women for drug treatment, if there are other children at home untended, the saving of one generation (the mother) at the cost of losing the next (the children at home) is a bad social bargain. TWO-generation strategies seem essential if we wish to break the cycle of dependency.

By 2010, we will know the answer to the question: what will a 22 year-old be like whose mother used crack and/or other drugs during pregnancy? The answers will range from institutionalization to graduation from college Summa Cum Laude, but the skew will be to the former, not the latter. Prevention seems to make an incredible amount of sense compared to cure. The question, however, that comes to mind is what price is society willing to pay for this personal choice of the mother, when it has to pay for the resulting damage done to the child by providing extensive hospitalization, additional education, etc.?

What Are The Costs?

The most important social cost to the nation is the hundreds of thousands of children born every year who are at risk of not fulfilling their potential through no fault of their own and therefore may be lost to society. Also, given that the crack addictive reflex is stronger than the maternal ones, many children living in households with an addicted adult present will likely suffer additional abuse and neglect. According to a recent study from the National Committee for Prevention of Child Abuse, substance abuse has become the "dominant characteristic" in the child abuse caseloads of 22 states and the District of Columbia. The "boarder babies" may be the lucky ones - they will at least be fed, clothed and loved regularly, even if it is by hospital staff and volunteers.

The most important social cost to the nation is the hundreds of thousands of children born every year who are at risk of not fulfilling their potential through no fault of their own.

Fiscal costs have to be pieced together. The health problems of drug-exposed infants and their longer and more complicated hospitalizations are often reflected in higher hospital charges. A report from the U.S. General Accounting Office (1990) found that ***hospital charges for drug-exposed infants were up to four times greater than those for infants with no indication of drug exposure***. For example, at one hospital the

median charge for drug-exposed infants was $5,500, while the median charge incurred by nonexposed infants was $1,400.

The *Kappan Special Report* (1992) indicated that the annual cost to the nation of intrauterine exposure to cocaine is now running between $33 million and $1 billion for newborns and between $351 million and $1.4 billion for first-year care. At the same time, the article noted that the U.S. spends $375 million for alcohol-exposed newborns, $652 million for tobacco-exposed newborns, and as much as $852 million for the care of tobacco-exposed children. In New York City, annual placements of drug-affected babies in foster homes have risen from 750 before the crack onset during the 1980s, to 3,500 in 1991 at a cost of $795 million. New York will also spend about $765 million over the next ten years on special education for drug-exposed kids, according to *Time Magazine*, (May 13, 1991).

The only strategy which helps babies who are born affected by drugs which is also reasonably cheap is prevention.

Florida is spending an estimated $40,000 dollars over the state average to get each of the 11,000 - 17,500 drug-affected children born each year in Florida ready for kindergarten, according to the Florida Department of Health and Rehabilitative Services. Because so many drug-affected children are born prematurely, they stay in the hospital much longer than average, and in very expensive "preemie" wards that can cost up to $9,000 a day. Falco suggests that $2.5 billion was spent in the United States in 1990 for intensive care for babies prenatally exposed to crack. It will cost an additional $15 billion to prepare them for kindergarten, according to the Elementary School Center (ESC) in New York.

A final item of concern related to cost has to do with the fragmentation of the services that are available. In *Neither Damned Nor Doomed* (ESC), a case study describes a single family being helped over a two-year period by 28 separate agencies, 58 professionals in all - case workers, child service workers, and guidance counselors. How could the family being helped even learn the names of those trying to help them? The question of how best to regroup these forces is very sticky. In the above example, ESC reports that $2.5 million was spent in the Borough of Queens (NY) just for meetings to discuss how to coordinate service programs! As one critic put it, "It takes a great manager to be poor."

The only strategy which helps babies who are born affected by drugs which is also reasonably cheap is prevention: helping women to stay away from drugs in the first place, especially while they're pregnant. Even making sure that the woman who has delivered one drug-affected baby will not deliver another one, an obvious gain for

everyone, turns out to be very hard to achieve. The forces for prevention are vastly outnumbered by the pressures for drug usage, especially in rural and inner city environments. Early intervention is the next best thing after prevention. The American people have yet to be heard from on the issues of how much they are willing to pay for early intervention and successful treatment of drug-affected mothers and children, and which programs they would give up for such an initiative. Whatever the costs for early intervention, it would be less than the cost in the long run for education, foster care, health care, and the cost for keeping these children in prison later on.

In the face of huge costs, there is no national consensus among local, state and federal sources on who should pay for what. There is no priority consensus at any level as to how programs for drug-affected children fit with programs to benefit other children who are involuntarily at risk: those born into poverty, orphans, those with purely genetic handicaps, those born to parents who reject and abuse them, and those born to handicapped parents.

Some Successful Programs

One highly successful program is Washington's D.C.'s "Project DAISY" (Developing Appropriate Intervention Strategies for Young Children) which started in 1989. "DAISY" is a fully inclusionary program in the D.C. Public School system and held in a regular early childhood classroom, with an early childhood educator and classroom assistant, and supported by a multi-disciplinary consultation team. The team includes a clinical psychologist, a clinical social worker, a speech/language pathologist, a nutritionist, and family partnerships. Children ages three to five are in the program. The work of the specialists is incorporated into the normal routine of the classroom and includes home-based intervention. Project DAISY, the program operators say, is very cost-effective and it is not as expensive as special education. According to the preliminary findings, (a full evaluation report will be released late in 1993) the prognosis is extremely good and further support the proposition that early intervention makes a big difference. The Project DAISY staff feels that none of the children participating in the program needed special education and that all could be fully integrated into regular education if a model similar to Project DAISY were provided.

The New York Times reported on February 16, 1993 that real success was being achieved at the Sheltering Arms Therapeutic Nursery in Harlem. The article made special mention of a girl who had shown marked improvement after four months in the program. In her classroom were ten children, FOUR special education teachers, and regular sessions were held with a speech therapist and psychologist.

This is a very expensive staffing ratio! (**Any child** would probably thrive with such ample staff resources available every day.)

A program with similar staffing ratios is the Salvin Special Education Center in Los Angeles, which conducted a three-year pilot program with 50 drug-exposed kids, ages three to five. Like the other two programs mentioned above, the Salvin program had small classes (eight pupils to one teacher), fixed seat assignments and rigid routine, generous warmth and praise, and protection from loud noises and other disturbing stimulation. More than half of the drug-exposed children have been able to transfer to regular school classes, with special tutoring and counseling.

Many programs are now beginning to show that many, if not most, drug-affected children can be helped to show enough improvement to join regular classrooms. The irony is that even though many programs are beginning to demonstrate success, funding for these programs is unlikely to be increased because states are currently under considerable budgetary pressures. Head Start and similar programs will have more political appeal, and may be defined as helping "the deserving poor," while many children born with drugs in their veins may truly find that the sins of the mother are visited upon the innocent children.

Legal And Ethical Issues

Many aspects of the law dealing with drug use and its consequences are at cross purposes. It is clearly in society's best interests to make sure that every pregnant mother gets at least one prenatal examination during the first trimester of pregnancy, even though as many as 20 percent of pregnant women may get NO first trimester examination. It is also a right of mothers to have privacy and protection from a potentially coercive government. In some states, a pregnant mother who is a drug user can be charged with child abuse (and if she has other children, they can be placed in foster care) when going to a medical facility for the recommended first physical, thus guaranteeing that she won't be back! In one jurisdiction, for example, transmitting drugs through the placenta to a fetus is not a crime, as the fetus is not yet a human being, but during the first minutes after birth, before the umbilical cord is cut, the mother can be legally charged with transmitting drugs to a minor, or child abuse.

It is clearly in the state's interest to ensure that drug-using women do not get pregnant, and to ensure that if they do, health and counseling services will be available.

It is clearly in the state's interest to ensure that drug-using women do not get pregnant, and to ensure that if they do, health and counseling services will be available, and (above all) to make sure that the drug-using woman does not produce additional children while under the influence of harmful drugs. Yet our legal system seems inadequate to protect the interests of both mother and child simultaneously. The law is drawn largely around individuals. It can deal with the mother, it can deal with the child, but it cannot deal with the dyad, the mother/child UNIT. Social services are often pointed in the same way - some drug de-tox programs will admit pregnant women, but only a handful will admit a pregnant woman and provide day care for her children at the same time.

A two-generation strategy is needed in both the law and social service areas. Many single mothers, anxious to acquire job skills, are unable to get such training because of the lack of available day care. The debate over whether to require Norplant usage for all women who are addicted to any dangerous substance (or teen mothers who have already given birth to one child) will usually be decided on the basis of the mother's interests, as a potential child, not yet conceived, is to some extent a legal nonentity. There is no way that the rights of a "nonentity" can be as fully protected as the rights of a living, breathing existing person.

As of 1993, it appears that, although it is in the state's best interests to have ZERO babies born with dangerous drugs coursing through their veins, the legal system cannot effectively prevent women from giving birth to such children. It is not yet clear that the numbers can even be reduced through efforts of the legal system, as the punishment threat is not effective, and the law works basically through sanction, not reward. The problem is NOT that the United States is a democracy, because virtually all other democracies make sure that ALL youth are healthy, well fed, and emanate from a supportive home environment. The problem is that we as a nation are guilty of child neglect, if not abuse. It is in the nation's best interest that we make sure that all children are healthy, well fed and come from a supportive home environment!

Both pro-life and pro-choice partisans have been singularly silent on the issues surrounding drug-affected mothers and babies. In fact, there seems to be no truly national organization except for the Children's Defense Fund (in Washington, D.C.) which is totally dedicated to improving the lives of the young children who ARE born. But even CDF does not emphasize the problems of drug-affected mothers and children very strongly. If one believes that abortion is murder, what is it if a drug-using mother gives birth to a full term child who dies in the first hour of life? If one believes in the unfettered right of a woman to choose, what if the drug-using mother chooses life and gives birth to a full term child who dies in the first hour of life? Both sides may see their arguments weakened by such cases.

Indeed, the more one thinks of the issues surrounding drug-affected children, the key points of intervention seem to be before conception and during pregnancy, two areas in which the law is VERY weak. Once again, the national debate over pro-life and pro-choice positions has blinded us to the extremely dangerous condition of many of the almost four million children who ARE born each year. Even with the optimistic news of partially successful treatment, to be born of a drug-addicted mother is to be born at serious risk. If treatment successes get major publicity, one consequence might be "don't worry about using drugs during pregnancy - if something's wrong with your child, they can fix it." Even in a democracy, it is important that society orchestrate its social, economic and legal rewards and sanctions to reduce or eliminate such occurrences.

A New Version Of The Social Contract: The "Prevention Contract"

The "mainline" family/youth attitude in the United States since World War II could be stated as follows:

- It is best for teenagers to abstain from sex until marriage.
- The use of illegal drugs should never be condoned, but especially by pregnant women, as they are harming the next generation.
- The enforcement of these values should be the responsibility of a team, consisting of parents (the biological mother and father), and the school and church working together to present a "united front."

When it is written out, as above, the mainline seems hopelessly obsolete, even ridiculous, to some adults today. As a result, children may never hear the mainline articulated, except when stated with derision. If that is the way adults present it, it is very hard to condemn young people for acting AS IF the mainline were obsolete! Yet, the authors have heard many community leaders fail to endorse abstinence from sex and drugs as the most desirable solution for some of youth's most difficult problems, as if to do so would be considered naive. Yet, it is clearly what virtually all parents desire for their own children.

It is unfortunate that so many children live in poverty primarily because they are being raised by a single parent, or by neither biological parent. The issue, as presented by then Vice President Quayle, as support for "family values" (which were never defined) was designed to avoid the real problems of children born into poverty

to parents who are unable to care for them. Yet the evidence is very clear that many more children are at risk in today's diverse families than was the case during the 1946-64 time period when the Baby Boom was born. (See *The Atlantic*, April, 1993, "Dan Quayle was Right," by Barbara D. Whitehead.) And yet, as the "Counterculture Generation" of the 1960s raises its own children, the mainline values are reasserting themselves.

The truth is that the PREVENTION side of the mainline value system has always been very much with us. No parent or guardian of a 12 year-old child in ANY kind of household arrangement would actively encourage that child to get involved with sex and/or drugs. Yet, parents of every kind of family seem overwhelmed today by the constant bombardment from the media and many "youth heroes" that sex and drugs are "where it's at." Parents also seem unable to work together with churches and other agencies to at least present the case for prevention/abstinence. If the case doesn't get made *consistently*, it's hard for young people to understand what adults want them to do. Just because families are more diverse in composition does NOT mean that we have to give up the prevention "mainline" agenda.

Even addicted pregnant women do not wish for their unborn children to be affected negatively by drugs, although they may feel helpless about doing anything to prevent it. In fact, many drug-using mothers have stated that they do not want their children involved with drugs. It is the case, however, that more often than not, the mother's addiction to drugs is much stronger than her desire to care for her child.

In order to prevent the obvious escalation of the percentage of our youth who are at risk of failure before they even get to the kindergarten door, all types of families have to rally to a common value - the "mainline" or prevention agenda. Until this happens, it is clear that schools, health and social agencies cannot do the job without parents. When parent participation has been mandated, as with Head Start and the "IEP," or Individual Education Plan, which parents of special education students must sign and be committed to, the results have ranged from good to spectacular. Although the contract strategy has been a good one for student learning, it has escaped major attention as a way of committing millions of parents of whatever family structure to the prevention agenda, for the obvious good of their children. With a signed contract from the parent(s) supporting the prevention agenda, social and educational services then play the role of supporting the parent/child contract to achieve the prevention agenda.

In the case of a mother who has given birth to a child who tests positive for cocaine, the contract would be her commitment to: (a) make sure that the child does not get involved with drugs; and, (b) make sure that she produces no more drug-affected babies. Social service agencies would then have the opportunity to

provide de-tox services and job training for the mother and day care for the child, in order for the mother to accomplish the contract's goals. Social and educational agencies would have a SPECIFIC reason for working together to implement the contract. Each "at risk" household would only sign off on one contract. All support agencies would use the contract as THE document for service delivery. The poor mother of two no longer has to tell her story to 20 separate agencies and many more people. Service integration is inherent in the contract. It could be argued that the parent/child's right to privacy as guaranteed in the First Amendment would be better protected under a contract system than the uncoordinated current state of delivering social services.

While the "social contract" model recommended here is in no sense a panacea, it does reflect the dual commitment to prevention and cure. It is vital that useful services be provided to drug-using parents and their children. It is ALSO vital that we do everything possible to reduce the need for such services in the future. One possibility is that successful "cure" programs may have the unintended consequence of reducing the urgency for prevention. (Why not use drugs during pregnancy if harmful consequences for both the child and mother can be ameliorated through publicly funded programs?) The ideal solution would be to continuously lower the number of drug users in the nation to the point where "cure" services would not be needed. At the moment, that does not seem to be a viable goal. As a result, we will probably have to engage in "triage" thinking for the foreseeable future, funding some prevention programs and some cure programs, without a coherent strategy for truly making the problem go away. Such a strategy could be developed around the signing of the "social contract" as a prerequisite for access to state and federal programs and services.

Conclusions

This paper has attempted to look as carefully as possible at the issue of drugs and mothers who give birth to children after using drugs during pregnancy from a perspective that differs from clinicians. We believe that enough evidence is available that indicates that we need to stop thinking about these children as all having unalterable deficits. We also believe that informed responses must be created which put the children born exposed to drugs at the center of the focus and which also provide an array of assistance from education to health services. Some of our conclusions about this complex issue follow.

- There is much evidence of a major increase in drug use in the U. S. during the 1985-1990 period, particularly the use of cocaine. It is also clear that increasing numbers of children are being born who

have dangerous drugs in their bloodstream at birth. (This is the case at least through 1990.) Although we are starting to see declines in self-reports of drug use and declines in terms of arrest of men and women who test positive for cocaine, the declines have not yet shown up in a reduced number of drug cases in hospital emergency wards, fewer "boarder babies" left in hospitals, foster care requests, etc. The safest estimate is that around 375,000 babies are born each year with dangerous drugs in their bloodstream. The actual number could be double.

- While some children may not be able to be helped, many, if not most, drug-exposed children can be brought to normal or near normal functioning by highly intensive (and expensive) programs so that they can be mainstreamed into regular school programs. In Florida, 17,500 cocaine-affected babies were born in 1987. The cost of getting these children ready for kindergarten in 1992 is estimated to be $40,000 per child, or $700 million total, according to the Drug Education Newsletter, (Spring 1990). One success mentioned in the *New York Times* article (cited earlier) used a pattern of ten children and four full time professionals, with other consultants coming in as needed. Project *DAISY*, in Washington, D.C. is in its third year mainstreaming drug-affected children into regular, early childhood classrooms, and the prognosis for these youngsters is very good. Like the children in the New York program, the children in the Project DAISY program are also in small classrooms with a team of professionals and other consultants coming in as needed. Most poor children, indeed **all** children, would show major gains with staffing ratios like those! The only thing that could be called cheap is prevention.

- Increased use of crack by females has produced increased rates of venereal disease and HIV/AIDS among women who turn to prostitution to support their crack habit, as well as more crack-affected babies. (Most women are poly-drug users, and the cocaine tests are not very reliable.) Because of the strength of the addictive reflex, an infant sent home with an addicted mother is very likely to become an abused and/or neglected child.

- Only a handful of drug treatment centers around the country will accept pregnant women and a tiny fraction of them will provide day care for existing children. Basically, there are few "two generation" treatment centers now in place that help the entire

family unit. Many relevant legal precedents also deal with individuals rather than the family.

- There is some conflict between the goals of prevention and the goals of treatment. If prevention were 100 percent successful, the treatment staff would be unemployed!

- Even in 1993, there are virtually no reliable state data on children born with dangerous drugs in their bloodstream. States also differ wildly in terms of their attitudes toward a drug using woman who is pregnant. In some states, she is inherently guilty of child abuse. No one can be sure if the numbers of such children are increasing, decreasing or constant. It IS clear that in middle income suburbia, many addicted pregnant women are able to keep their situation private. The problem is probably larger than we know since there is no consistency across hospitals that test both the mother and child for drug abuse.

- The pro-life/pro-choice debate has drawn attention away from the serious problems of the children who ARE born.

- Even during the 1960s, a "mainline" value system excluded children from the idea that "Doing Your Thing" was always right. Today, this common core of values about children could become an integrative mechanism that virtually all Americans could support as they relate to children and youth. It is proposed that one way of getting the family back into the middle of the social services debate is the notion of a family development/prevention contract in which education, health care, and social service agencies collaborate, while keeping the family unit at the center as the accountable unit for fulfilling the contract.

- Oddly enough, the topic of drug-exposed children, having been a media hit during 1990-1992 season, virtually disappeared from the TV screens in the last half of 1992 and the first third of 1993, (with the exception of the Hallmark Special aired in May 1993). No national commission reports have been issued and no "bio underclass" exposes have been published in the weekly news magazines. The issue surprisingly has lost visibility (except in health-related scientific journals) just as some reports of successful treatment for addicted mothers and children were beginning to make their way onto the back pages of newspapers right next to the want ads, as well as in some small circulation research journals.

Perhaps the best evidence for hope is the reported decline generally in crack-cocaine use. **The experts believe that even though it is hard to determine exactly how much the crack epidemic is ebbing, virtually every possible index of crack and cocaine use over the past five years shows a decline.** In New York City, for example, the number of men and women arrested who tested positive for cocaine has dropped steadily since 1988. The number of births to women testing positive for cocaine and crack during pregnancy in New York also fell between 1989 and 1991. Similar declines have also been reported in other cities. According to a recent article in *The Washington Post*, the generation that took to the drug five and 10 years ago is sorely depleted -- in jail, physically and emotionally exhausted by the drug or dead from the violence that accompanied it. The experts believe that in a pattern that is being repeated nationwide, many teenagers coming of age in drug-ridden neighborhoods have seen the damage crack has done to their parents and their friends and are turning against it. However, even if drug use among pregnant women is declining, the problem remains a very serious one.

- It may be that The Clinton Administration can frame a national policy toward the issues surrounding drug-affected children, but given the diversity of state demographics in the U.S., the implementation of such a policy would have to be heavily state-based. The issue will have little political appeal, as drug-using pregnant women are not likely to vote in any election! The problem is clearly not going away, only our attention to it is. But the rock has been thrown into the pond of life, the ripple of children born with drugs has started to move out to the edge of the pond. If no more drug-affected babies are born after 1993, we still need to be concerned about the issue for 60 more years, as these children become adults and move through the life cycle. What will be the cost over a child's lifetime of being born affected by drugs? We do not know, but we will all find out and pay.

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